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Health Care Reform, Access to Care, and Dentistry

The Patient Protection and Affordable Care Act of 2010 (PPACA) was signed into law by President Obama on March 23, 2010 and took effect on January 1 of this year. Some of the many provisions of PPACA have begun, and most will be implemented by 2014, with full implementation occurring in 2019. It is projected that PPACA will result in health care being provided for 32 million new, primarily low-income, previously uninsured beneficiaries.[1] Unfortunately, government estimates place the number of uninsured in 2019 at an additional 23 million (approximately 42% of those currently uninsured). PPACA is expected to result in Medicare savings to the government of $575 billion between 2011 and 2019, while Medicaid payments to Academic Health Centers (AHCs) are expected to be cut by nearly $40 billion for exceptional care payments.[2] It is clear that efforts are in progress to repeal PPACA, but the balance of power between Congress and the Executive Branch of our government is such that repeal in the foreseeable future is unlikely.

Foster[2] and Shomaker[3] have estimated that AHCs will bear the brunt of providing the care for these 32 million new patients and will serve as safety net providers for the burgeoning influx of new health care recipients. Shomaker goes on to make the following recommendations to AHCs for dealing with health care reform legislation:

- AHCs must train the workforce needed within their regional service areas.
- AHCs must expand the number of physicians being trained, and shorten the time needed to train them.
- AHCs must commit to training mid-level providers to help manage the huge influx of new patients.
- AHCs must improve the diversity of medical school classes to enhance the training of the workforce.
- AHCs must revise their curricula to provide trainees with the skills needed to practice in tomorrow's health care environment.
- AHCs must explore new partnerships, and improve existing ones with safety net providers, especially Federally Qualified Health Centers (FQHCs) and Area Health Education Centers (AHECs).
- AHCs must create actual or virtual integrated care networks with community providers to improve cost efficiency.
- AHCs must maximize revenues and reduce expenses to survive in the financial challenges of post-PPACA.
- AHCs must move aggressively to improve clinical quality and safety.
- AHCs must lead the way in the translation of basic science research into clinical care.

Will PPACA affect dentistry? Absolutely! Simply add dentistry to Shomaker's list of 10 recommendations above, since dentistry IS a part of the AHC campus, and imagine the impact on current schools of dentistry. In organized dentistry, both the American Dental Association and the American Dental Education Association believe that all Americans deserve good oral health. As more and more evidence emerges of the close relationship between oral health and general systemic health, dentistry must play a vital role in the decision-making process for improving the general health for all patients. Currently, health care disparities exist in the US, and cross geographic, economic, age, gender, and ethnic boundaries. Dental disease, especially caries, is the most prevalent malady affecting children in the United States, and very low percentages of disadvantaged children see a dentist regularly. In time, these children will become OUR patients. This, coupled with relatively poor reimbursement rates for those patients covered by Medicaid, CHIP, and other third-party providers, suggest that many general dentists cannot afford to treat (or refuse to treat) disadvantaged patients. And, since most schools of dentistry are associated with AHCs, the likelihood of growing patient populations descending on the schools for care is very likely. Clearly, the access to care issue is real, and PPACA will exacerbate it—just consider the consequences of 32 million new (to dentistry) patients becoming eligible for some form of dental care by 2014.

So, how do we provide for the workforce needed to meet the expected demand? I see several possible scenarios:

- Construct more dental schools (currently, there are 10–14 in planning or under construction).
- Incentivize graduates of existing schools of dentistry to practice in rural areas through educational loan debt relief.
- Expand the DDS class size at existing schools of dentistry.
- Identify more extramural rotation sites in underserved areas (through Health Departments, FQHCs, AHECs, Indian Health Service sites, mobile dental clinics, etc), and have our current students spend more of their training time in off-site rotations.
- Train mid-level dental providers (Dental Health Aide Therapists [DHATs], mid-level providers, expanded duty dental assistants, etc), and place them in underserved areas (supervision?).
- Develop new, and expand current, international dental programs to educate dentists who received their DDS/DMD degrees abroad, in 2-year US training programs.
- Consider accrediting international schools of dentistry, and change the current State and Regional Board examinations to allow those from international schools to apply for licensing examinations.

Unfortunately, the ONLY short-term solutions are for state governments to provide incentives to current dental students to practice in underserved areas, or to consider the accreditation of international schools. And, there are no guarantees that the accreditation of international schools, or 2-year training programs for international dentists would encourage ANY of those

graduates to practice in underserved areas. I would suggest offering loan incentive repayment options of two years of service for full repayment of a year of academic indebtedness, or at the least, year-for-year repayments. With the average dental student graduating with debts in excess of $150,000, I believe the loan repayment incentive is the best option for short-term success. Any of the training programs suggested would require a minimum of two (for mid-level provider training) years, up to as many as 10 years (developing, building, and graduating a class in a new school of dentistry) to begin to address the access to care issue, which may be a too-little, too-late approach. The short-term solutions will not be the most popular with organized dentistry, with the practicing dentist, or with licensing boards. Unfortunately, we must be proactive, rather than reactive to this issue. If you do not agree with what has happened in Alaska, Minnesota, or is likely to happen in Vermont, simply ignore the problem in your state and hope your local government ignores it as well. Let me know how that works out for you.

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Editor-in-Chief

References

1. www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.
2. Foster RS. Available at: www.cms.gov/ActuarialStudies/Downloads/PPACA_go2010-04-22.pdf.
3. Shomaker TS: Preparing for health care reform: Ten recommendations for Academic Health Centers. Acad Med 2011 [Epub ahead of print].

Apology

In the February issue of the *Journal of Prosthodontics*, Dr. Barry Goldman was listed as a co-author of "Salese to Buffer Saliva in Elderly Patients with Xerostomia: a Pilot Study." Dr. Goldman's affiliations were incorrectly listed. He should have been listed as the Former Director of the Postgraduate Prosthodontics Program at Nova Southeastern College of Dental Medicine, Ft. Lauderdale, FL, and as an Emeritus Professor of the Medical College of Georgia, Augusta, GA. We regret the errors.